



BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

LONG TERM ACUTE CARE PRE-ADMISSION EVALUATION

Please fax this form to the Patient's Care Coordinator at **BLUE CROSS AND BLUE SHIELD**.
For precertification, fax form to 1-205-733-7020 or call 1-855-288-8357.

Please Print Legibly

| | | |
|---|---|---|
| Facility Name | | In Blue Cross Network <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Facility Address (City, State, Zip) | | Phone Number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Patient Name | Date of Birth <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Contact Number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Patient Address (City, State, ZIP) | | Phone Number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Other Insurance Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Veterans Administration <input type="checkbox"/> Commercial | | Contract Number |
| Caregiver Name | Caregiver Home Phone Number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Caregiver Cell Phone/Alternate Number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Referring Physician | | Referring Physician Phone (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Referring Physician Address (City, State, ZIP) | | |
| Referring Hospital Name | Hospital Phone Number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Admit Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Hospital Contact Name | | Hospital Contact Number (<input type="text"/> <input type="text"/> <input type="text"/>)- <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Referring Hospital Address (City, State, ZIP) | | |
| Primary Diagnosis for Admission to LTAC | | |
| Secondary Diagnosis | | Anticipated LOS |
| LTAC Referral Discussed with Patient/Caregiver? <input type="checkbox"/> YES <input type="checkbox"/> NO | | |

Planned Treatment Intervention (Please document specific physician's orders.)

| |
|--|
| Ventilator Weaning |
| Oxygen |
| IV Therapy |
| Medications |
| Wound Care |
| Nutrition |
| Rehab Therapy |
| Specialty Needs (DME, HD, Telemetry, etc.) |

Discharge Plan (From LTAC)Discharge Destination: Home Home Health Assisted Living Facility Inpatient Rehab SNF LTC Hospice

Prior Living Arrangements:

Home DME: Wheelchair Hospital Bed Assistive Device Other _____House/Apartment/Other: Levels 1 2 3 | Number of Steps Entrance _____ Number of Steps Inside _____ Ramps _____

Facility

InterQual® Admission Criteria: Check applicable subset

 CVPV Infectious Disease Medically Complex Respiratory Complex Vent Weaning Wound/Skin**History of Current Hospitalization (Please Fax H & P)**

Primary Acute Diagnosis:

Surgery This Admission:

Prior Level of Function:

Current Level of Function:

Respiratory Oxygen Home O2 Nasal Cannula _____ liters/min Mask@ _____ percent Ventilator Bipap

Ventilator Settings: MODE _____ RATE _____ TV _____ PEEP _____ FiO2 _____ PS _____

Tolerating Weaning Attempts YES NO | Number of Attempts _____

Current ABGs _____ pH _____ PCO2 _____ HCO3 _____ PO2 _____ SaO2 _____

Current CXR YES NO | Date _____ Results: _____ Intubated ET Tube Tracheostomy | Date _____Other Lines: Chest Tube Drainage Device Dialysis Catheter CVPV Telemetry

Neurological

Musculoskeletal

GI

Nutrition

Albumin:

HT/WT:

CONFIDENTIALITY NOTICE:

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